July 1, 2002

The Honorable Michael K. Powell
Chairman
Federal Communications Commission
445 12th Street, SW
Washington, DC 20554

Re: 47 CFR Part 54 Rural Health Care Support Mechanism [WC Docket No. 02-60; FCC 02-122]; Proposed Rulemaking (67 *Federal Register*, 34653), May 15, 2002

Dear Chairman Powell

On behalf of our nearly 5,000 hospital, health system, network and other health care provider members, the American Hospital Association (AHA) welcomes the opportunity to respond to the Federal Communication Commission's (FCC) proposed rule on the rural health care universal service support mechanism.

The Telecommunications Act of 1996 was intended to create competition that fostered the deployment of new and various telecommunications services at affordable rates. Congress also intended for the universal service support mechanism to provide discounted telecommunications services to health care providers in rural communities.

Advances in technology have lowered bandwidth requirements and equipment costs for all health care providers. However, transmission costs continue to be high, limiting the development of telemedicine in rural areas. The universal service support mechanism for rural health care has become an important component of rural health service delivery, helping to ensure access to health care for many rural communities by providing discounted telecommunication rates for telehealth activities. Rural hospitals that participate in the Rural Health Care Universal Service Program are not only able to achieve substantial savings on telecommunications costs, but are also able to provide needed health services.

For example, as a result of universal service, rural physicians and other health care professionals can participate in patient consultations with distant tertiary care facilities, using technologies such as interactive video teleconferencing that eliminates the need for patients and families to travel long distances.

However, improvements are needed if the rural health care universal service support program is to reach its full potential. Our major concerns are summarized below. A detailed discussion and recommendations on specific technical issues in the proposed rule – eligible health care providers, Internet access, calculation of discounted services, and application process – are contained in the attachment.

- We are concerned about the current application process. It is complex, cumbersome and frustrating, and discourages many rural hospitals and other eligible health care providers

from taking advantage of the program's benefits. Extensive marketing and educational campaigns should be developed to make rural health care providers aware of the program's benefits.

- The current rural health care universal service mechanism as applied to the telecommunications companies (telcos), which are key components of the program, does not work well. For example, the program rules do not specify the time in which a telecommunications company must respond to the completion of the Rural Health Care Division's (RHCD) forms. This lack of response creates huge budget and cash flow problems for rural hospitals receiving the discounts and adds to frustration with the program. The application process should be simplified and a process for multi-year applications should be created.

- To successfully fulfill the intent of Congress, the current definition of "health provider" should be expanded to other rural non-hospital care settings where services are provided to patients.

We appreciate the opportunity to work with you to improve the rural health care universal service support mechanism. If you have any questions or need additional information, please feel free to contact John Supplitt, senior director for small or rural hospitals at (312) 422-3306.

Sincerely,

Rick Pollack
Executive Vice President

Attachment

Attachment

Comments by the American Hospital Association on the Proposed Rule for the Rural Health Care Universal Support Mechanism

On May 15, 2002, the Federal Communications Commission (FCC) published in the *Federal Register* a notice of proposed rulemaking (NPRM) to modify existing rules governing the Rural Health Care Support Mechanism for rural health care universal service support. The NPRM asks for comments on several general categories of issues, including:

- whether to clarify how the FCC should treat eligible entities that also perform functions that are outside the statutory definition of "health care provider;"
- whether to provide support for Internet access;
- whether to change the calculation of discounted services, including the calculation of urban and rural rates;
- whether and how to streamline the application process;
- whether and how to allocate funds if demand exceeds the annual cap;
- whether and how to modify the current competitive bidding rules;
- whether and how to encourage partnerships with clinics at schools and libraries; and
- measures to prevent waste, fraud, and abuse.

Comments and recommendations addressing these areas of the FCC's NPRM follow. Where possible, the title and paragraph number from the NPRM is referenced.

Eligible Health Providers **(NPRM paragraphs 6-10)**
Since implementation of the Rural Health Care Universal Service program, the FCC has limited eligibility to the seven categories of providers enumerated in the Telecommunication Act of 1996 (the Act). These categories are post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools; community health centers or health centers providing health care to migrants; local health departments or agencies; community mental health centers; not-for-profit hospitals; rural health clinics; and consortia of health providers consisting of one or more entities as described above.

In the proposed rule, the FCC affirms that eligible health care providers are limited to the seven categories enumerated in the statutory definition. However, the FCC has asked whether it should enable an entity that allocates some of its resources to "rural health clinic" services or in another capacity that would qualify it as a "health care provider" under the Act to be eligible for a discount. The proposed rule states that there are rural health clinics and emergency service facilities not currently eligible for support because they are operated by entities that also function as nursing homes, hospices, and other long-term care facilities.

Comment: The statutory definitions create an anomaly regarding eligibility of nursing homes and other services provided by rural hospitals, such as hospice and emergency medical care. These services may be lodged in buildings that are not on the hospital campus. For example, many rural hospitals provide post acute care services through skilled nursing units that are an integral part of the hospital; nursing homes that are attached to the hospital; or nursing homes not located on the hospital campus. According to universal service statute and regulations, only distinct skilled nursing units would be able to participate in any telemedicine/telehealth effort because such units are an integral part of the rural hospital. Other critical rural health and medical services, such as long-term care, hospice, and emergency medicine, that are included within the corporate structure of the rural hospital, but not lodged on the hospital campus, are precluded from receiving universal service discounts.

Health care facilities such as nursing homes, hospices, emergency departments, and non-eligible rural health clinics all provide vital health care services to their communities. Many of these organizations operate on extremely tight budgets. Subsidized telecommunications will enable these organizations to provide additional services such as psychiatric consults, treatments for nursing home residents, or emergency medicine consultation that may not be otherwise available. These services can effectively be provided over telehealth (videoconferencing) without having to transport residents to a distant hospital or clinic. Further, when inclement weather and seldom-traveled roads are considered, it may not be in the best interest to transport patients long distances, but, instead, to let them remain in their communities.

The AHA recommends that the definition of "health provider" be expanded to include rural nonprofit nursing homes, hospices, emergency medical facilities, currently noneligible rural health clinics, home health agencies, skilled nursing facilities, public health agencies, and other health care providers without regard to tax status. This recommendation may require a statutory legislative change.

Internet Access **(Paragraphs 11-20)**

In the *Universal Service Order*, 62 FR 32862, June 17, 1997, the FCC authorized limited support for Internet access for health care providers. The FCC found that rural health care providers incur large telecommunications toll charges and that those charges were a major deterrent to full use of the Internet for health-related services. Therefore, the FCC provided support for toll charges incurred by all health care providers that could not obtain toll-free access to an Internet Service Provider (ISP). The support was limited to $180 or 30 hours of usage per month.

In the proposed rule, the FCC states that support for toll charges is not being used by applicants. Virtually all rural health care providers have access to an ISP without incurring toll charges. The FCC asks whether support for toll charges to ISPs should be eliminated, and that support instead go toward any form of Internet access provided to health care providers.

Comment: Rural health providers can potentially benefit from support for Internet service. The most efficient and cost-effective way to provide many telehealth services may be via the Internet in the future. Some networks are already beginning to use broadband Internet and Intranet services to provide quality video connections for the delivery of interactive encounters between

providers and patients and for teleradiology services. High-speed access to the Internet will also allow health care providers to access on-line health education for their employees, and, in the near future, allow them to access telehealth services with high reliability and security. When combined with Virtual Private Networking (VPN), broadband services can also provide a cost-effective method for outreach sites to connect into a regional network. However, broadband Internet services are still limited in many rural areas.

Access to on-line health education is crucial for employees of rural health care providers, including hospitals, nursing homes, and clinics. Without such access, employees have to travel to obtain mandatory education and continuing education credits.

The AHA recommends that support for toll charges be eliminated and that discounts instead should support any form of Internet access provided to rural health providers that exceeds the cost of similar services in urban areas of the state.

Implementation of Internet Access **(NPRM paragraph 16)**
The Rural Health Care Universal support program is one of four universal service support programs. Another is the Schools and Libraries program. Under the Schools and Libraries support mechanism, basic access to the Internet, including e-mail, is eligible for discount. In the NPRM, the FCC asks whether a percentage discount on Internet charges, analogous to the schools and libraries support mechanism, is preferable, or whether a rural/urban rate comparison should be used.

Comment: All entities and consortiums that are eligible for support for "standard" telecommunication services, T1, ISDN, etc, should be eligible for Internet access support. There should be no restriction on the connection type for Internet services as those services can be provided over any number of telecommunication lines.

Discounts should be provided to underwrite access to Internet connectivity via any modality, to include "non-telecommunications service providers." In some communities, other providers of telecommunications technology, such as the local cable operator or public utility board, have chosen to provide broadband access to the Internet. Health care providers that choose to access those services should be eligible for discounts if that telecommunications technology provides service that supports medical purposes. The discount structure should be simple, efficient and administratively straightforward.

The AHA recommends that a simple discount structure be instituted to support Internet access for health care providers with Universal Service and that a fixed percentage of the cost of Internet access up to a maximum cap per health care provider be permitted.

Interpretation of Similar Services **(NPRM paragraphs 26-29)**
In the proposed rule, the FCC states that it has been the policy to base discounts on the difference between urban and rural rates between the same or similar services. The FCC also states that this policy may have created inequities between urban and rural health care providers. The policy does not take into account that some less-expensive urban services are unavailable at any price in

rural areas, requiring rural providers to seek out more-expensive services. The FCC asks whether the present policy should be changed so that discounts are based on comparisons between and among different types of high-speed transport offered by telecommunications carriers that may be viewed as functionally equivalent by end-users.

Comment: Most rural health care providers do not have access to the broad telecommunication services available to urban health care providers. Digital Subscriber Line (DSL) services are available in most urban areas, and are a cost-effective means of connectivity for health care applications. These services are much less expensive than bandwidth-comparable services such as ISDN, Frame Relay or dedicated T-1/fractional T-1 connectivity. Unfortunately DSL has not reached into a majority of rural America.

The delivery of telehealth services is moving toward an Internet Protocol (IP) environment. In that sense, whether the transport mechanism is T1, ISDN, Frame Relay, ATM, or DSL, the IP environment is still the same. This renders the transport mechanism moot to the extent the bandwidth of the transport is the same. Therefore, the FCC must recognize the convergence of telehealth networks and informational networks. When using an IP-based network for telehealth, both audio/video and data are running within the same informational stream. It is the end user devices (e.g., CODECs, teleradiology systems, PCs, etc) that translate the digital information into something useful for telehealth. Broadband services such as cable and DSL should not be viewed as Internet services only, but also as access methods. When combined with VPN, they can provide a cost-effective method for outreach sites to access the main network as opposed to installing high-cost private lines that would likely be underutilized.

The AHA recommends that universal service support should be provided based on functionality of the end-user, so 1.5M bandwidth connectivity provided by a dedicated T-1 to a rural hospital (where DSL is not available) should be comparably priced as a DSL circuit providing the same bandwidth to an urban hospital. The AHA recommends that the services be segmented into private network (dedicated T1, T3) and public network (DSL, Cable, Frame Relay, ATM) for comparison purposes. A private network is more secure, has lower latency and travels a defined route, whereas a public network is less secure, has potential for high latency, and can travel an infinite number of paths.

Further, with the convergence of networks toward IP and the transport mechanism being moot, the AHA requests that the FCC not differentiate between telehealth networks and informational networks, and continue to look at comparable bandwidth options between rural and urban areas.

Urban Area **(NPRM paragraphs 34-35)**

Section 254(h)(1)(A) of the Act requires the FCC to provide support for "rates that are reasonably comparable to rate charges for similar services in urban areas in that state." Under the FCC rules, the urban rate is based on the rate for similar services in the "nearest large city," which is defined as the "city located in the eligible health provider's state, with a population of at least 50,000. . . ." Experience with the rural health care universal service support mechanism indicates that many rural health care providers choose to link their telemedicine networks to

pockets of expertise located in larger cities in the state. In the NPRM, the FCC requests comments on whether to alter its rules to allow comparison with rates in any city in a state. (underscoring added)

Comment: The Telecommunications Act of 1996 did not mandate a rate comparison to the nearest city of 50,000. This requirement was added by the FCC when it developed its initial rule. In many cases, patient referrals bypass the nearest city of 50,000. Selection of the "nearest" urban area artificially places undue constraints on referring physicians within a state or relevant geographic region. In addition, the assumption that services used by rural health care providers would likely involve transmission links to the nearest city is not always the case. In fact, many rural hospitals and health systems own facilities that are located in rural areas miles from the main health care campus. However, because the rural site may also be, for example, 35 miles from the closest city of 50,000, the discount available to the hospital or health system for a telehealth connection is based on parameters associated with the city 35 miles away. In short, the current rules unnecessarily hamper the hospital's/health system's ability to provide telehealth services. Subsidization of the communication service via the universal service mechanism is limited to the distance to the nearest city of 50,000.

The AHA recommends that the FCC allow comparisons based on rural telecommunications costs/rates to any urban area in the state or relevant geographic region.

Maximum Allowable Distance (MAD) **(NPRM Paragraphs 38-41)**
The MAD is a restriction in the FCC rules that limits support for rural health care providers to distances less than the "distance between the eligible health care provider's sites and the farthest point from that site that is on the jurisdictional boundary of the nearest [city of a least 50,000]". In establishing the MAD, the FCC believed that this approach would be sufficient to connect the health care provider to adequate telehealth services, and would also protect against health care providers requesting telemedicine connections to distant areas in search of experts for consultations. In the NPRM, the FCC states that limiting rural health care providers to the nearest city of 50,000 or more may not be adequate for the creation of a comprehensive telemedicine network. The FCC requests comments on eliminating or revising the MAD restriction.

Comment: The concept of telehealth is to eliminate distance as a barrier to the provision of the best possible health care. In this sense, there should be no maximum allowable distance for telehealth services. Removing the MAD will offer rural health care providers greater flexibility in developing appropriate telehealth networks and improve the delivery of health care in rural areas. Further, calculation and administration of the MAD is time- and labor-intensive. Elimination of the MAD restriction will help to simplify the application process.

In the NPRM, the FCC suggests that the MAD could be calculated as the distance between the rural site and the nearest tertiary care center. The nearest tertiary care center may not participate in the telehealth network. In addition, health plans may pose limitations on which tertiary center can be used for certain services.

The AHA recommends elimination of the MAD restriction.

Streamlining the Application Process **(NPRM Paragraphs 44-46)** In the NPRM, the FCC requests comments on how to streamline the application process to make it more accessible to rural health care providers. The FCC also seeks comments on how to eliminate delays and lack of response from eligible telecommunications carriers in supplying the information necessary for rural health providers to complete the process.

Comment: Since issuance of the 14th and 15th Orders on Reconsideration of the Universal Service Order, the RHCD has attempted to simplify the application process. Initiatives to improve the program include on-line form access, electronic certification for two of the forms, and the ability to file an initial application on-line. In addition, the RHCD conducts monthly conference calls with applicants, telecommunications service providers, and others interested in the program to discuss issues surrounding program implementation, rules, and requirements.

However, the application process needs to be further simplified so that it is no longer a barrier to entry. Applying for universal service support requires a Health Care Provider (HCP), telecommunications carrier(s), and RHCD to complete a multi-step process that is extremely cumbersome and very time-consuming, involving completion of four forms and 12 steps. It is common for eight months to pass between the initial application and the receipt of the universal service discount. In some instances, it takes more than a year.

A major barrier is lack of cooperation by the telecommunications companies in completing Form 468 and returning it to the health care provider. Rural health care employees play mutiple roles in a difficult environment and are unable to devote significant time to the complex and confusing process of filing, obtaining rate information from the telecommunication companies, and completing the forms for universal service funding. A process should be developed to allow filing Form 466 (Services Ordered and Certification) and Form 468 (The Telecommunications Providers Support) on-line, similar to the process for Form 465 (Description of Services Requested and Certification) and, as of April 29, 2002, the process for Form 467 (Receipt of Service Confirmation). In addition, the RHCD Web site could include a reference/index area that lists pertinent information alphabetically, similar to the Reference Area that has been developed for the Schools and Libraries Division.

Currently, the health care provider has to reapply for support every year. For cases where a multi-year contract has been signed after a competitive bid process, the RHCD should develop a simplified process where the applicant and the telecommunications provider can indicate and attest to the fact that no change in service has occurred and that the service is still eligible for universal service discounts.

One of the main problems that rural health care providers have with the application process is lack of response from eligible telecommunications companies in completing the necessary forms. Personnel in the telecommunications offices change frequently, and new personnel are unfamiliar with the program. Delays in completing the necessary RHCD forms often in turn cause delays in rebates to the health care provider. This creates major accounting and financial

problems for rural facilities. Extensive education is needed to encourage telecommunications carriers to fulfill their responsibilities under this program. In addition, the FCC should consider imposing penalties for any delays caused by the telecommunication carriers.

The AHA recommends that the RHCD simplify the application process as described above, and, most importantly, develop a simplified process for multi-year contracts so that health care providers do not have to reapply on an annual basis.

Pro-Rata Reductions If Annual Cap Exceeded **(NPRM Paragraphs 47-48)** Under the current rules, if total demand for support exceeds the cap of $400 million, the administrator is to divide the total annual support available by the total amount requested in that year, then multiply that result, (the pro rata factor), by the amount requested by each applicant. The FCC requests comments on whether this approach is the most effective and equitable means of distributing funds, or whether an alternative approach should be adopted.

Comment: If the cap is exceeded, there will be a need to reduce distribution. However, it seems unlikely that the cap will be exceeded since not even 10 percent of the $400 million allocated on an annual basis has been distributed to health care providers. Data from the RHCD indicate that for FY 2000, $10.756 million has been committed to 743 applicants.

The AHA recommends that the FCC study this issue further and develop explicit alternatives that can be reviewed by interested parties.

Preventing, Waste, Fraud, and Abuse **(NPRM paragraphs 49-55)**

Competitive Bidding **(NPRM paragraphs 49-51)** The NPRM requests comment on the effectiveness of the rural health care universal support mechanism's competitive bidding rules.

Comment: In many rural areas, there is only a single telecommunication service provider. Where more than one exists, a competitive bidding process is likely to have already taken place. In addition, to receive cost-effective rates, health care providers often enter into multi-year contracts with their telecommunications service provider.

The AHA recommends that, where competitive bidding is done and long-term contracts have been signed, the RHCD create simplified forms for the applicant and telecommunications provider to sign and stipulate that the service is still in place and that the rates have not changed.

Encouraging Partnerships with Clinics at Schools and Libraries **(NPRM paragraph 53)** The NPRM asks for comment on two issues: How to encourage rural health care providers to pool resources with other entities to limit costs themselves and utilize support more efficiently, and whether clinics in schools should be eligible for discount under the rural health care support mechanism or the schools and libraries support mechanism. In some instances, both mechanisms have denied support to the clinic by stating that the other support mechanism must be contacted.

Comment: Partnerships between schools and libraries and clinics should be encouraged. The RHCD and the Schools and Libraries Division should collaborate to determine what portion of the circuit each will fund. For example, if the school has lines that are utilized by both the school and the clinic, then both divisions should support their proportional share. If the lines are used by the clinic exclusively, such as for telemedicine, then the RHCD should fund the lines. These partnerships should not be forced, however, as clinical data and transmissions need to remain highly secure and confidential. If the clinic or hospital chooses to install separate lines and not share them with another entity supported by the USAC (Universal Service Administrative Company) the clinic or hospital should be free to do so, with security and privacy the reasons.

The AHA recommends that partnerships between schools and libraries and clinics be encouraged. Further, the AHA recommends that if the clinic or hospital chooses to install separate lines for security or privacy reasons and not share them with another entity, the clinic or hospital should be free to take such action.

Further Comments on Issues of Concern **(NPRM paragraph 55)**

Current Low Application Rate: The low application rate is due to many factors, including:

- lack of knowledge of the program by health care providers;
- uncooperative telecommunications service providers;
- misconception that funding is only for telemedicine applications;
- lack of understanding that future planned telecommunications networks, as well as those currently installed, are eligible for funding support;
- previous difficulty with the application process has prevented health care providers from reapplying;
- some health care providers believe they are not eligible; and
- complex, confusing, and frustrating process.

Marketing and outreach should be increased substantially. Rural health care providers in all states need to be aware that the program exists and that they may be eligible to receive discounts on their telecommunications costs.

The AHA recommends that the FCC and the USAC develop extensive and intensive marketing and educational campaigns to make rural health care providers aware of the benefits of this program.

Definition of "Rural" Among Federal Programs: As specified in the May 7, 1997, FCC Report and Order on Universal Service (paragraphs 504 and 647), "rural areas should be defined in accordance with the definition adopted by the Department of Health and Human Services' Office of Rural Health Policy (ORHP/HHS). ORHP/HHS uses the Office of Management and Budget's (OMB) Metropolitan Statistical Area (MSA) designation of metropolitan and non-

metropolitan counties (or county equivalents), adjusted by the most currently available Goldsmith Modification, which identifies rural areas within large metropolitan counties."

However, the ORHP no longer uses the above definition for all of its grant programs. For example, in the application materials for Rural Access to Emergency Devises Grant (93.259), the ORHP states that this year the ORHP is using new methodology to determine rural eligibility. The ORHP is using the Rural Urban Commuting Area Codes (RUCAs), developed by the WWAMI (Wyoming, Washington, Alaska, Montana, and Idaho) Rural Research Center at the University of Washington and the Department of Agriculture's Economic Research Service, to designate "Rural" areas within Metropolitan Areas. Adoption of the new definition by ORHP means that health care providers could qualify as "rural" under one federal program but not for other programs. This situation may further complicate issues of eligibility within federal programs designated for rural health care providers.

The AHA recommends that the non-urbanized area definition that applies to both the rural health clinic and swing-bed programs under Medicare be used to determine "rural" eligibility. The definition of rural for both the rural health clinic and swing-bed hospitals follows:

A. Rural Health Clinic: 42 CFR Ch. IV (10-1-01 Edition) § 491.5 Location of clinic.

(c) Criteria for designation of rural areas. (1) Rural areas are areas not delineated as urbanized areas in the last census conducted by the Census Bureau.

(2) Excluded from the rural area classification are:
(i) Central cities of 50,000 inhabitants or more;
(ii) Cities with at least 25,000 inhabitants which, together with contiguous areas having stipulated population density, have combined populations of 50,000 and constitute, for general economic and social purposes, single communities;
(iii) Closely settled territories surrounding cities and specifically designated by the Census Bureau as urban.

(3) Included in the rural area classification are those portions of extended cities that the Census Bureau has determined to be rural.

B. Swing-Bed Hospital: 42 CFR Ch. IV (10-1-01 Edition) § 482.66 Special requirements for hospital providers of long-term care services (''swing-beds'').

a. Eligibility (2) The hospital is located in a rural area. This includes all areas not delineated as ''urbanized'' areas by the Census Bureau, based on the most recent census.

Effect on Demand for Support: The rural health care mechanism is underutilized. Only approximately $10.7 million in funding has been committed for 2000, although the rural health care support mechanism has been capped at $400 million per funding year. Even after providing for additional classes of eligible health care providers, allowing for additional funding for Internet access and streamlining the application process, it is doubtful that the $400 million cap will be reached without dedicated outreach efforts from the FCC.

The AHA recommends that the key to generating a significant increase in the application rate for the universal service program will be an effective outreach and technical assistance program that encourages health care providers to file for universal service funding.